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Summary of the Pilot Project Evaluation of the Alberta Assessment and Placement Model for Long-Term Care Services

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Prepared for:
Assessment and Placement Pilot Project Committee

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1. INTRODUCTION

1.1 Background

Alberta, like many jurisdictions in Canada and the United States, faces an increasing demand for long-term care services. To address the rising demands and costs anticipated for the long-term care system the Alberta departments of Hospitals and Medical Care and Community and Occupational Health and the Alberta Mortgage and Housing Corporation agreed to establish a coordinated assessment and placement system for all long-term care services. In October 1984, the Interdepartmental Committee on Long-Term Care, comprised of representatives of the three departments, developed the Assessment and Placement model (the model).

The Ministers of the responsible departments subsequently decided to test the model on a pilot basis in rural and urban regions of the province. This pilot project was coordinated by the Assessment and Placement Pilot Project Committee (the Pilot Project Committee) comprised of representatives from the three sponsoring departments, health care groups and each pilot region.

The Assessment and Placement model was designed to ensure a single point of entry to long-term care services provided by Home Care Programs, nursing homes and auxiliary hospitals to the elderly and the disabled of all ages. The model is based on the philosophy that care will be provided at the lowest (least costly) level consistent with the client's needs and, where possible, non-institutional services will be considered the first point of entry to the long-term care system. The community-based entry point includes an emphasis on and commitment to maintaining and strengthening family and community involvement.

The model includes initial assessment of client needs by Home Care Case Coordinators (HCCCs) and placement of clients in appropriate services by HCCCs or Institutional Case Coordinators (ICCs). Regional Assessment and Placement Committees are responsible for institutional placement activities and coordination of institutional placement activities with community assessment and placement activities. Community and Occupational Health funded pilot project assessment activities through the participating health units and Hospitals and Medical Care funded pilot project placement activities through the nursing home and auxiliary hospital districts.

In October 1985, Price Waterhouse was retained by the Department of Hospitals and Medical Care to evaluate the pilot implementation of the model. The two regions piloting the model were:

- for the rural region, the area covered by the Foothills Health Unit, including long-term care institutions in High River, Black Diamond, Vulcan and Carmangay; and

- for the urban region, the area covered by Calgary Health Services, Carewest and approximately one-half of the area covered by the Mount View Board of Health.

The rural pilot project began in February 1986, and the urban pilot project in April 1986.

1.2 Evaluation Approach

The principal strategy for the evaluation was to measure the performance and impacts of the entry, referral and assessment arrangements **before and after implementation** in the two pilot regions. Information regarding model processes, client impacts and system impacts was obtained from five sources:

- interviews with key participants before, during and after implementation of the model;
- a telephone or in-person survey of client satisfaction before and after implementation of the model;
- agency data forms on referrals to long-term care before and after implementation of the model;
- case studies of the referral, assessment and placement process during model implementation; and
- provincial information on costs for assessment and placement activities and long-term care services, statistics on long-term care service use and demographic information about Alberta's elderly population.

Collection of the evaluation data was undertaken just before the model was implemented (in the first quarter of 1986) and approximately 15 months after implementation (in the last quarter of 1987).

Other features of the evaluation included an implementation analysis to examine the degree to which the model was implemented as planned and to identify any constraints to implementing the model; a case study review of the referral, assessment and placement process; and a limited and qualified cost analysis and benefit assessment of the model's implementation in the pilot regions. The sources of information collected during the evaluation are noted below.

Table 1: Sources of Evaluation Information

Information Source	Before Pilot	During Pilot (9 mos.)	After Pilot (15 mos.)
Interviews	48	48	48
Client Surveys	380		380
Agency Data Forms	1,049		1,590
Case Studies		12	
Provincial Information	X	X	X

Note: X indicates demographic information, service statistics and cost information included in the evaluation.

The terms of reference for the evaluation were to:

- evaluate the strengths and weaknesses of the model compared to the current situation;
- evaluate the feasibility, suitability and applicability of the operation of the components of the model in the pilot regions, including adaptations to meet local needs;
- provide a cost analysis and assess the benefits of implementing the model in the pilot regions; and
- provide opinions on province-wide implementation based on the results derived from the above analyses.

Detailed information regarding the evaluation strategy, data analysis, implementation analysis, case study review and the assessment of costs and benefits, are presented in the *Technical Report of the Pilot Project Evaluation of the Alberta Assessment and Placement Model for Long-Term Care Services* (Price Waterhouse; August, 1988).

This report summarizes the evaluation of the implementation of the community-based entry point of the Assessment and Placement model in the two pilot regions. The Technical Report includes the extended analyses and evidence which support the major conclusions highlighted in this report. To develop our conclusions, we examined information regarding model processes, client impacts and system impacts. Each conclusion is based on multiple indicators developed from the five evaluation information sources noted in Table 1.

1.3 Interpretation of the Evaluation Results

The 48 interviews undertaken in October 1987, primarily addressed system impacts of the model. In February 1988, the Committee for Long-Term Care for Senior Citizens, chaired by Mrs. Diane Mirosh (MLA, Calgary Glenmore), released the discussion paper *A New Vision For Long-Term Care: Meeting the Need* (commonly referred to as "the Mirosh Report"). The Mirosh Report recommended comprehensive measures to respond to the needs of the elderly within the resources of the Province of Alberta, and has been associated with extensive discussion and debate by individuals, professionals and organizations concerned about long-term care of Albertans. In recognition of the dynamic environment of long-term care, the Mirosh Committee activities and other developments in the long-term care sector may have affected opinions regarding the system impacts of the model as the evaluation proceeded. Implementation and evaluation of changes to the long-term care referral and assessment process is not a single event, but rather an ongoing **dynamic process** of implementation, evaluation and adjustment. Through this dynamic process interview respondents may refine their opinions regarding the impact of changes to the long-term care system.

During implementation of the model a number of important initiatives were undertaken within the long-term care sector. These initiatives included:

- development of a common and comprehensive assessment instrument for use by long-term care services (the Alberta

Assessment and Placement Instrument, AAPI);

- development of the Alberta Patient Classification System to determine the care requirements of nursing home residents and auxiliary hospital patients and to provide an important component for funding of long-term care institutional services;
- development of special assessment services for the elderly;
- development of services for the mentally dysfunctioning elderly;
- development of community service care options for the elderly; and
- the Mirosh Committee for Long-Term Care for Senior Citizens.

These and related initiatives may have influenced the implementation of the model and the impacts of the model. The evaluation approach was based on before and after implementation comparison without control regions, as appropriate control regions could not be identified. As a result, the evaluation approach available to the Pilot Project Committee did not enable clear determination of which effects were directly associated with the model compared to effects which may be associated with other initiatives in the long-term care sector.

The evaluation included considerable data from pilot project participants representing a variety of independent agencies and organizations. The participating agencies and organizations use somewhat different definitions to classify referrals, assessments, reassessments, placements and case management activities; and somewhat different procedures to record and monitor referrals, assessments, reassessments, placements and case management activities. Because of the differences in definitions, and recording and monitoring procedures, the evaluation results must be interpreted cautiously.

After the Assessment and Placement model pilot projects were initiated, a number of regions in the province developed and implemented variations of the model. The evaluation is restricted to the two pilot regions and does not address the effects and impacts of referral, assessment and placement processes in other regions of the province.

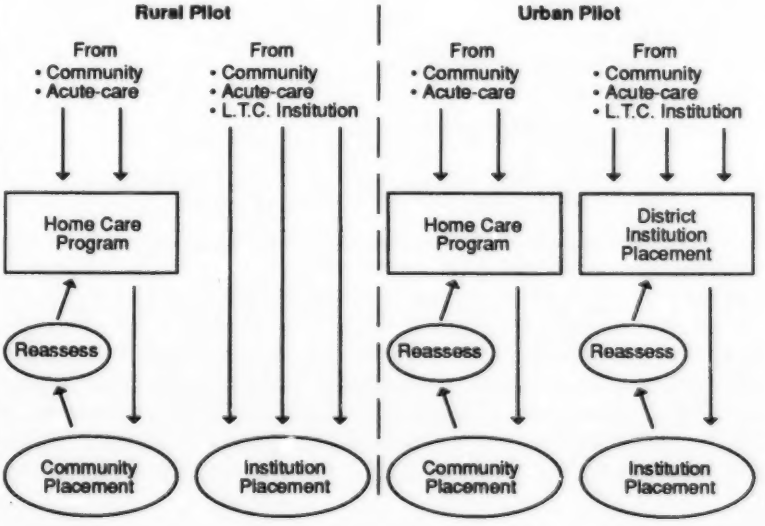
2. ASSESSMENT AND PLACEMENT

2.1 Before Model Implementation

2.1.1 Rural Pilot Region

Before the model was implemented in the rural region, clients and families applied or were referred to individual providers of long-term care services including the Home Care Program, nursing homes and auxiliary hospitals (Figure 1). Home Care nurses assessed, managed, reassessed and provided nursing services to Home Care Program and Community Health Nursing program clients. The rural region Home Care Program received lower than average funding compared to other Home Care Programs in the province before the model was implemented. Each nursing home and auxiliary hospital accepted the Alberta Hospitals and Medical Care "290 form" as application for institutional services, assessed applicants as required, and maintained and managed a waiting list. There were no formal procedures for reassessment of nursing home and auxiliary hospital patients in the rural region.

Figure 1: Assessment and Placement Referral Process Before the Model



In 1984 the rural region had an estimated population of 32,356. About 10.1% (3,263) of the population was 65 years of age or older (*Assessment and Placement Pilot Project Proposal: Foothills Region*). The rural region included 115 active-treatment hospital beds, 48 auxiliary hospital beds, 86 nursing home beds, and 184 lodge beds. The rural Home Care Program had about 369 clients and about 88% of these clients were over the age of 65 (March 1986). In January 1986, fifteen active-treatment hospital beds and patients were reclassified to auxiliary hospital status. For the duration of the pilot project the reclassified auxiliary hospital was involved in extensive renovation and pilot project participation was therefore restricted.

2.1.2 Urban Pilot Region

In the urban region clients and families applied or were referred to the Home Care Program or Carewest's institutional placement service (Figure 1). On receipt of the Alberta Hospitals and Medical Care "290 form," Carewest nurses assessed potential institutional clients and maintained and managed institutional waiting lists for facilities in Carewest's district. Carewest reassessed nursing home and auxiliary hospital patients on a request basis. Home Care nurses assessed, managed, reassessed and provided nursing services to Home Care Program clients. Unlike other Home Care Programs in the province, Calgary Home Care admissions to long-term care accounted for approximately 50% of all Home Care admissions. (In other programs long-term care Home Care admissions account for about 80% of all admissions. Home Care admission categories include long-term care, discharges from active-treatment hospitals, rehabilitative care and palliative care.)

In 1986 the urban pilot region had a total population of approximately 640,500, with about 6.8% (43,100) 65 years of age or older (Calgary Corporate Resources). In 1985 the urban pilot region had 2,725 active-treatment hospital beds, 1,438 auxiliary hospital beds, 2,282 nursing home beds, 936 lodge beds, 4,085 senior citizen units, a psycho-geriatric day-hospital and two day-hospital programs providing services to 50 clients (*Proposal to Pilot the Assessment and Placement Model for Long-Term Care: Calgary Region*). The urban region Home Care Programs had about 1,944 clients and about 80% of these clients were 65 years of age or older (March, 1986).

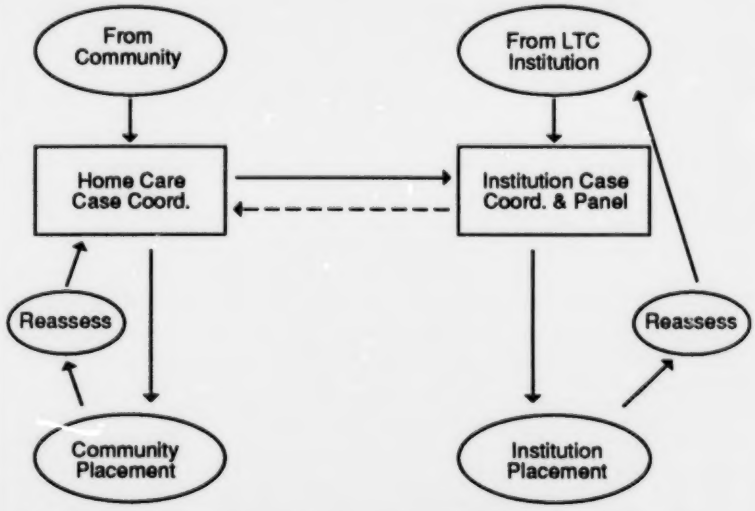
2.2 The Model

The Assessment and Placement model is described fully in *An Assessment and Placement Model for Long-Term Care Services in Alberta*, commonly referred to as "The Green Book." Individuals requiring long-term care services are assessed by HCCCs who develop a placement recommendation based on a comprehensive assessment of client needs. Individuals recommended for Home Care Program services are placed and case managed by HCCCs. Individuals recommended for nursing home or auxiliary hospital placement are placed and case managed by ICCs.

Specific objectives of the model are:

- to recognize and treat assessment and placement as separate functions;
- to foster a case management approach in the assessment, placement and discharge process;
- to coordinate assessment and placement functions;
- to relate appropriate client services to client need and choice;
- to use the most cost-effective and efficient services based on client need and choice;
- to emphasize the use of community-based services whenever possible;
- to involve clients and families actively in both the assessment and placement decision-making processes;
- to enhance family and community responsibility in the provision of long-term care;
- to handle referrals and other matters promptly and effectively; and
- to establish an independent appeal process accessible to clients, service providers, physicians and other participants.

Figure 2: Assessment and Placement Model Referral Process



2.3 Model Process and Structures

Figure 2 indicates the referral, assessment, case management and placement process in the two pilot regions. The entry point to long-term care services is the HCCCs. HCCCs assess, refer, case manage and place Home Care clients and lodge residents who require Home Care. Potential nursing home or auxiliary hospital patients are assessed by

HCCCs and referred to the ICCs. Patients in active-treatment hospitals who have not received long-term care services or have been receiving lodge, Home Care or other health or social services (e.g., services from multiple sclerosis clinics) are initially assessed by HCCCs.

Nursing home and auxiliary hospital patients are assessed, reassessed, case managed and placed by ICCs. Patients in active-treatment hospitals who have been in a nursing home or auxiliary hospital are assessed or reassessed by ICCs. In the rural pilot institutional placements are reassessed regularly and in the urban pilot institutional placements are reassessed on a request basis.

Regional Institutional Placement Panels review all recommendations from HCCCs for nursing home or auxiliary hospital placement (rural region) and the complex or difficult cases referred by ICCs (urban region). The multi-disciplinary Placement Panels include a physician, nurse, rehabilitation therapist, social worker, lodge representative (rural region) and psychologist/psychiatrist (urban region). In the rural region HCCCs recommend an appropriate level of institutional care to the Placement Panel who provide the placement decision. In the urban region ICCs determine appropriate levels of institutional care or refer cases to the Placement Panel for a placement decision.

Figure 3: The Assessment and Placement Pilot Project Reporting Structure

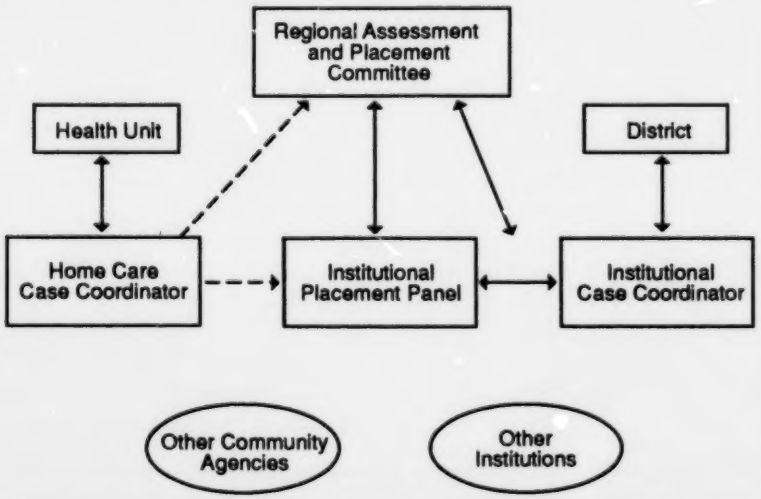


Figure 3 indicates the reporting structure for assessment and placement agencies participating in the pilot projects. The rural Regional Assessment and Placement Committee includes representatives from the Home Care Program, lodges, a member of the public at large, and representatives from all active-treatment hospitals, nursing homes and auxiliary hospitals in the pilot region. The urban Regional Committee includes representatives from Calgary Health Services, the Mount View Board of Health, Carewest, active-treatment hospitals, Calgary

medical community, private nursing homes, voluntary nursing homes and voluntary auxiliary hospitals. The Regional Committees are responsible for institutional placement activities and coordination of institutional placement activities with community assessment and placement activities. The ICCs report to the Regional Committees and the local nursing home and auxiliary hospital boards. The HCCCs report to their local boards of health.

The Regional Assessment and Placement Committees reported to the Assessment and Placement Pilot Project Committee, who reported to the Interdepartmental Committee on Long-Term Care. Placement activities were funded by the Department of Hospitals and Medical Care through the nursing home and auxiliary hospital districts, and assessment activities were funded by the Department of Community and Occupational Health through the health units. During the pilot period the Department of Community and Occupational Health provided additional funding to the pilot regions to support increased caseloads.

In both pilot regions lodges maintained their assessment and admission policies. In the rural region the lodges are very active participants in the pilot project referral, assessment, case management and placement process. In the urban region the pilot project includes the development and maintenance of a computerized Client Information System.

3. EVALUATION RESULTS

3.1 Objectives of the Assessment and Placement Model

This section of the report summarizes the extent to which the pilot projects achieved the objectives of the model and indicates the applicability and suitability of the objective for the pilot regions. For the purposes of this report, evidence that an objective has been met is classified as "strong, moderate or some." The strength of the evidence was determined by examination of the pattern of evidence and included consideration of the following factors:

- did an indicator of model effects provide evidence that the model objective was achieved;
- did multiple indicators of model effects derived from one information source provide consistent trends;
- did multiple indicators of model effects derived from different information sources provide consistent trends;
- were multiple indicators consistent with achievement of an objective primarily quantitative (and based on objective information) or primarily qualitative (and based on subjective information); and
- did the multiple indicators provide a comprehensive assessment of achievement of an objective.

Figure 4 (opposite page) summarizes the evidence and information sources for each objective. The order of the objectives in Figure 4 does not necessarily correspond with the priority of the objective. During the course of the pilot projects, the objectives were expanded and different priorities emerged. Objective 5 was not assessed quantitatively because appropriate financial and statistical data required for the analysis were not available. Due to differences in definitions, and recording and monitoring procedures, we were unable to provide a rigorous analysis of cost-effectiveness.

The opinions and perceptions of interview respondents reflect the experience of the respondents with the pilot project process as of October 1987. Because respondents may have refined their opinions since October 1987 and because of differences in definitions of and recording procedures for the assessment and placement process, the results of the evaluation of the model pilot projects should be interpreted cautiously.

Figure 4: Evidence that Assessment and Placement Model Objectives were Achieved

Objective	Evidence Found Rural	Urban	Information Source
1. To recognize and treat assessment and placement as separate functions.	Strong	Strong	• interviews • client survey • agency logs • case studies • provincial information
2. To foster a case management approach in the assessment and placement process.	Strong	Some	• interviews • agency logs • case studies
3. To coordinate assessment and placement functions.	Strong	Moderate	• interviews • agency logs • case studies
4. To relate appropriate client services to client need and choice.	Strong	Strong	• interviews • client survey • case studies
5. To use the most cost-effective and efficient services based on client need and choice.	Moderate	Some	• interviews • agency logs • case studies • rural pilot project data
6. To emphasize the use of community-based services whenever possible.	Strong	Moderate	• interviews • client survey • agency logs • case studies • provincial information
7. To involve clients and families actively in both the assessment and placement decision-making processes.	Strong	Moderate	• interviews • client survey • case studies
8. To enhance family and community responsibility in the provision of long-term care.	Moderate	Some	• interviews • client survey • case studies
9. To handle referrals and other matters (a) promptly and (b) effectively.	a) Moderate b) Strong	Moderate Strong	• interviews • client survey • agency logs • case studies
10. To establish an independent appeal process accessible to clients, service providers, physicians and other participants.	Moderate	Moderate	• interviews • client survey • case studies

Objective 1: To recognize and treat assessment and placement as separate functions.

There was strong evidence that assessment and placement functions were recognized and treated as separate functions in both the rural and urban pilot projects. Rural respondents suggested that greater flexibility between the two functions may be more efficient and effective in the rural region. With greater flexibility between the roles of the rural HCCCs and ICCs, personnel could be assigned duties in response to demands. For example, if new referrals to long-term care increased, ICCs could undertake initial assessments. Urban respondents suggested that complete separation of the two functions was associated with duplication of assessment for individuals referred to ICCs by the HCCCs.

Objective 2: To foster a case management approach in the assessment, placement and discharge process.

There was strong evidence that the case management approach was fostered in the rural region and some evidence to indicate that case management was fostered in the urban pilot project. Urban respondents indicated that the model did not address the role of active-treatment hospital discharge planners in the assessment, placement and case management process.

Objective 3: To coordinate assessment and placement functions.

There was strong evidence that assessment and placement functions were coordinated in the rural region and moderate evidence of coordination in the urban region. Interview respondents suggested that the pilot project reporting structures may have encouraged adversarial roles for HCCCs and ICCs and that it may be more effective to assign responsibility for assessment and placement functions to one organization (agency or committee).

Objective 4: To relate appropriate client services to client need and choice.

There was strong evidence that appropriate client services were related to client need and choice in the rural and urban pilot regions, given the available long-term care resources.

Objective 5: To use the most cost-effective and efficient services based on client need and choice.

Subjective, qualitative information provided some evidence that the most cost-effective and efficient services based on client need and choice were utilized in the pilot regions. Information provided by the rural region indicated that a portion (15.3%) of clients recommended for institutional services were maintained in less costly, community-based services. Appropriate data required for rigorous analysis of cost-effectiveness were not available. Interview respondents indicated that use of the most cost-effective and efficient services was restricted by the available long-term care resources in both pilot regions, as well as by client or family choice.

Objective 6: To emphasize the use of community-based services whenever possible.

There was strong evidence of an emphasis on the use of community-based services in the rural region and moderate evidence in the urban region. Pilot project participants indicated that community-based services could be further emphasized if the maximum expenditure per client for community services was increased and if the number (or portion) of community service clients at the maximum expenditure level was increased. Current legislation theoretically sets the maximum expenditure per day for Home Care clients at par with the nursing home per diem rate (at about $50 - $55 per day: $36 - $39 is paid by the province and the remainder is paid by the resident). Due to limited Home Care Program funds, the actual maximum expenditure per client per day must be set much lower than the nursing home per diem rate.

Objective 7: To involve clients and families actively in both the assessment and placement decision-making process.

There was strong evidence that clients and families were actively involved in the rural assessment and placement decision-making process and moderate evidence for the urban region. The evidence indicated moderate to strong involvement of clients and family in the placement decision-making process before the model was implemented in the pilot regions.

Objective 8: To enhance family and community responsibility in the provision of long-term care.

Subjective, qualitative information provided moderate evidence that family and community responsibility in the provision of long-term care was maintained in both pilot regions and moderate evidence of enhancement in the rural region. The available data did not allow assessment of quantitative evidence relating to this objective.

Objective 9: To handle referrals and other matters promptly and effectively.

There was moderate evidence that referrals and other matters were handled promptly, for the rural and the urban region. There was strong evidence that referrals and other matters were handled effectively, for both pilot regions. As anticipated, implementation of the model was associated with increased waiting time between referral and placement due to the introduction of comprehensive assessment and the emphasis on consideration of community-based service options before consideration of institutional service options. Recognizing the changes in the assessment process, referrals were handled promptly and effectively in both pilot regions.

Objective 10: To establish an independent appeal process accessible to clients, service providers, physicians and other participants.

Independent appeal processes were established in both pilot regions.

There was moderate evidence that the appeal process was accessible to clients, service providers, physicians and other participants. Very few appeals were initiated. The majority of appeals addressed issues of availability of long-term care resources in relation to client choice (e.g., consideration of a client who does not want to move to another town/city to access the most appropriate service according to client needs).

3.2 Impacts of the Model on the Long-Term Care System

After the model was implemented in the pilot regions the number of referrals for long-term care services increased. Under the model, referrals to HCCCs were expected to increase as HCCCs began to assess clients whose needs indicated placement in an institution. Before the model was implemented clients bound for institutions often by-passed the Home Care Program.

Overall, the increase in the number of referrals to long-term care services suggests that new groups of clients who would not otherwise have accessed long-term care services **may** have been encouraged to access these services. This potential "case finding" effect of the model may be the result of different methods of classifying, reporting and monitoring referrals, assessments, reassessments, placements and case management activities. Assessment of client needs is an **ongoing process** which takes account of **changes in the client's status** while the client is waiting to access services or while the client receives services. In order to determine whether the model is associated with a "case finding" effect, the agencies and organizations involved in the referral, assessment, case management and placement process must use standardized definitions to count referrals, assessments, reassessments and case management activities.

Home Care Program caseloads increased in both pilot regions after the model was implemented and the Department of Community and Occupational Health provided funds to support the increase. New admissions to the Home Care Program tended to be 75 - 84 and 85 years of age or older, while the increase in the population was largest in the group 65 - 74 years of age. Similar results also were found for admissions to nursing homes and auxiliary hospitals indicating that after the model was implemented new admissions to the long-term care system generally were older, and presumably frailer. As anticipated, the quantitative and qualitative results of the evaluation provided some evidence that implementation of the model in the pilot regions was associated with a "screening effect" where use of lower (less costly) long-term care services was enhanced.

Information from the rural region provided moderate evidence that referrals waiting for institutional placement were more likely to be maintained in lower (less costly) services after the model was implemented. Before model implementation a client may have waited for a nursing home bed in an active-treatment hospital bed and after model implementation a client may have waited for a nursing home bed at home or in a lodge with Home Care Program services.

3.3 Impact of the Model on Clients and Families

After the model was implemented in the pilot regions clients and families were more aware and knowledgeable of alternative long-term care services. Over time, this increased awareness and knowledge of alternative services may be associated with increased demand for scarce resources (e.g., day hospital and day care programs).

Before and after implementation of the model clients and families indicated they were satisfied:

- that their preferences, feelings and needs were understood;
- that the recommendation for services resembled what they thought they needed;
- with the time and effort it took to get long-term care services; and
- with the experience of seeking services.

After the model was implemented clients and families indicated they waited somewhat longer to access long-term care services. In the rural region actual waiting time increased for some of the new referrals to the long-term care system who eventually received Home Care Program services. In the urban region actual waiting time increased for new referrals to the long-term care system who eventually received institutional services.

There was some evidence that implementation of the model may have been associated with less physician involvement in the referral, assessment and placement process. The AAPI assessment is a comprehensive assessment indicating the client's functional status including the client's ability to manage the tasks of daily living (dressing, bathing, cooking) and the client's social and behavioral status. Some interview respondents indicated that because medical conditions can affect a client's functional status, it is important to ensure that physicians continue to participate in the process of identifying and addressing the client's medical status.

3.4 Issues Related to Feasibility, Suitability and Applicability of the Operation of the Components of the Model

The pilot projects demonstrated that it is feasible to implement the community-based Assessment and Placement model. The available information did not allow precise identification of the costs, benefits and cost-effectiveness of the model and the model components. Qualitative information obtained from the interviews and the case studies, however, addressed the suitability and applicability of the components of the model and the issues that effect the operation of the components of the model. This section summarizes the major issues regarding the suitability and applicability of the model and the model components in the pilot regions.

3.4.1 Use of the Comprehensive Assessment Instrument (the AAPI)

Because the AAPI and the model were introduced simultaneously, the effects of the model cannot be distinguished from effects due to the introduction of the comprehensive assessment form (the AAPI). In the initial stages of the urban pilot alternative procedures for administering the AAPI were introduced and informally evaluated. In July 1987 a final modification for administering the AAPI was introduced in the urban pilot. Urban respondents indicated that the modified AAPI procedure improved the efficiency of the referral, assessment and placement process. Rural HCCCs and the ICCs indicated complete confidence in AAPI assessments and strongly recommended that the community-based Assessment and Placement model include the AAPI assessment.

Interview respondents indicated that the model should include a comprehensive and standardized assessment, but recommended phased implementation of the AAPI, followed by the model. The evaluation results indicated that implementation of the model and the AAPI was associated with some increases in waiting time. Generally, respondents thought increases in waiting time between referral for and placement in long-term care services would be offset by more appropriate placements and a more cost-effective long-term care system.

3.4.2 Separation of Assessment and Placement Functions

Interview respondents indicated that more flexibility or a combined role for HCCCs and ICCs may be more suitable in the rural region as personnel could be assigned duties to respond to changing demands for assessment and placement services. Respondents and the evaluation data suggested that the separation of assessment and placement functions may have been associated with duplication of assessment activities in the urban region and may not be suitable within the urban active-treatment hospital sector. Interview respondents did not reach a consensus regarding alternatives that would be more suitable for the urban environment.

3.4.3 Case Management

Interview respondents indicated that the increased case management of long-term care referrals was a major strength of the model operations in the rural pilot regions.

Urban respondents indicated that case management was similar in the urban pilot region before and after implementation of the model. Before the model was implemented the urban region had centralized institutional placement services. Generally, respondents indicated that the model did not address the role of active-treatment discharge planners in the referral, assessment and placement process. The evaluation results provided some evidence that the active-treatment sector plays a large role in determining referrals to the long-term care sector and that clarification and simplification of the referral process within the active-treatment sector could improve the efficiency and effectiveness of the model.

3.4.4 Community Care Service Resources

Interview respondents and the evaluation results indicated that all referrals for long-term care services were considered for placement in the Home Care Program. Respondents also noted, however, that there must be sufficient resources to maintain clients in the Home Care Program in order to ensure a long-term care system which encourages and enhances use of community-based services. With limited resources only a small proportion of Home Care clients are provided moderate to extensive community services. Respondents suggested that an assessment and placement process which encourages the use of community-based services over institutional services would require access to community-based services involving moderate to extensive services. Interview respondents also noted that the maximum Home Care expenditure per client that current funding levels allow, may not be sufficient to maintain clients whose needs otherwise indicate nursing home or auxiliary hospital placement.

3.4.5 Assessment Function in Home Care Programs

Interview respondents thought initial assessment by a community-based professional or agency ensured consideration of community-based service options before placement in a long-term care institution. Initial assessment by HCCCs from Home Care Programs was viewed as working reasonably well in the pilot regions some 15 months after the model was implemented. Rural respondents recommended incorporation of the Regional Assessment and Placement Committee within the health unit organizational and administrative structures.

3.4.6 Coordination of Services

The increased coordination of services and the increased understanding that long-term care service providers and active-treatment hospital staff gained through participation in the model pilot projects were perceived as major advantages.

3.4.7 Role of the Regional Assessment and Placement Committee

Interview respondents indicated that the Regional Assessment and Placement Committee may not be the most appropriate structure for managing and coordinating assessment and placement services. Generally, the pilot project committees, funding mechanisms and reporting process were viewed as cumbersome and inefficient. Respondents recommended a more traditional structure including:

- a Regional Committee responsible for setting policy and priorities;
- one manager with authority and responsibility for implementation of assessment and placement activities;
- one funding source **or** one position/agency responsible for managing funds from multiple sources; and
- a clear reporting structure for assessment and placement personnel at the regional and provincial levels.

Some respondents cautioned that an independent organization providing assessment and placement services (i.e., an organization that does not provide long-term care services) could lead to a more expensive health care system that would not necessarily provide benefits commensurate with the expense. These respondents suggested that another participant in the assessment and placement process would likely develop another administrative support system, potentially using resources that could be targeted at service provision.

3.4.8 Regional Institutional Placement Panel

Rural respondents indicated that the multi-disciplinary Institutional Placement Panels had been instrumental in the diversion of clients from the institutional long-term care service sector. Interview respondents generally noted that the Panel, which establishes the credibility of the assessment and placement decision-making process, is an important resource for the HCCCs and ICCs.

3.4.9 Regional Boundaries

The rural pilot project used the health unit boundary to define the region; the urban pilot project used the nursing home and auxiliary hospital boundary. The urban pilot project included two health units: Calgary Health Services and about one-half of the area covered by the Mount View Board of Health.

Rural respondents generally recommended the use of health unit boundaries, consideration of larger areas to ensure a range of community and institutional health care services within one region, and consideration of the size of regions such that case coordinator travel time to major centers is minimized. Representatives from Mount View suggested boundaries defined by the socio-economic relationships between cities and towns (e.g., quality of roads, citizen shopping patterns). For provincial implementation, respondents suggested the Province develop regional boundaries loosely based on health unit boundaries and adjusted to ensure:

- a range of community and institutional health services;
- reflection of established socio-economic relationships; and
- reasonable travel time to major centers within boundaries.

4. SUMMARY

The Assessment and Placement model pilot projects demonstrated the feasibility of implementing the model and achieving the objectives of the model. Major strengths of the model included:

- recognizing and treating assessment and placement as separate functions;
- fostering the case management approach;
- coordination of assessment and placement functions;
- relating appropriate client services to client need and choice;
- emphasis on the use of community-based services whenever possible;
- active involvement of clients and families in placement decision-making process;
- maintenance and potential enhancement of family and community responsibility for provision of long-term care services;
- establishing procedures to handle referrals and other matters promptly and effectively;
- establishing independent and accessible appeal process;
- potential for increasing use of lower (less costly) long-term care services;
- increasing awareness of and knowledge about long-term care service alternatives by clients and families;
- maintenance of high satisfaction by clients and families with the referral, assessment and placement process;
- increasing coordination of long-term care service providers;
- increasing understanding between long-term care service providers and active-treatment hospital sector; and
- establishing multi-disciplinary review of clients recommended for institutional placement.

We believe that the initial objectives of the community-based Assessment and Placement model were met in the pilot project regions and that significant modifications were made to the referral, assessment and placement process for long-term care services. The limited and qualified review of costs and benefits associated with the model provided information which suggests the model has the potential to encourage use of less costly, community-based, long-term care services.

Review of the operations of the components of the model revealed a number of issues which require further clarification prior to provincial implementation. These issues are noted below:

- development of standardized definitions to classify, report and monitor referrals, assessments, placements and case management activities;
- investigation of the potential of the model to attract new groups of clients to long-term care services that might not otherwise access these services; and consideration of strategies to manage new groups of clients requesting long-term care services;
- investigation of the potential of the model to encourage duplication of assessment activities, particularly within the urban active-treatment hospital sector; and consideration of strategies to minimize duplication of assessment activities;
- development of strategies to enhance the role of physicians in the referral, assessment and placement process for long-term care services;
- identification of long-term care service resources required to meet increasing expectations of clients and families regarding access to Home Care, day hospital, day care, night care and respite services;
- review of the pilot project reporting structures, roles and responsibilities to identify one organization with authority and responsibility for assessment and placement activities. Such an organization could be established at the provincial level, regional level or at provincial and regional levels; and
- rigorous and detailed cost benefit analysis to:
  - determine costs associated with the components of the model,
  - determine actual dollar savings associated with the model, and
  - estimate savings associated with the model as the elderly population of Alberta increases.

Implementation of system changes, such as the Assessment and Placement model, involve a process of implementation, evaluation and adjustment, implementation and further evaluation and assessment. We believe that with a relatively modest incremental cost, many of the issues identified through piloting of the model can be addressed to further improve the community-based Assessment and Placement model for long-term care services.

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